2019 Greenfield-Central Community School Corporation

MEDICAL / Rx ENROLLMENT FORM

Enrollment Instructions:
This Enrollment Form lists your benefit options, use this form to elect or decline your benefit coverage(s). **PLEASE PRINT.**

Reason for Electing/Changing Benefits

☐ Open Enrollment Period ☐ Qualifying Life Event: _____ Date of Event: _____

☐ New Employee ☐ Change (address/beneficiary etc.): _____

Employee Information *Please provide the following information about yourself and your employment*

Name	SSN	Date of Birth	Gender (M / F)

Street Address	City	State	ZIP	Phone Number

Email Address	Department/Occupation	Hire Date	Date Employed Full Time *If different than original hire date*

Employee Status	Hours worked per week	Marital Status	Authorized to work in the U.S.
☐ Active ☐ Retiree ☐ Full-Time ☐ Part-Time		☐ Married ☐ Never been married ☐ Divorced ☐ Separated	☐ Yes ☐ No

Medical

Election

☐ Decline Coverage

Election	Single	Family
	(check applicable category)	
CDHP 1	☐	☐
CDHP 2	☐	☐

Wellness Screening Premium Discounts

If the employee (and spouse-if covered) completed the Wellness Screening in 2018. Your premium discount will be applied to either plan you select in 2018. $250 for Single coverage and $500 for Family Coverage (available only if **Both** employee and spouse completed the screening.) Covered dependent children, regardless of age, are not required to complete the screening.

Covered Dependent Information – REQUIRED (Failure to provide *COMPLETE* information will delay / prevent a dependent from being enrolled)

*You need to provide information for **all dependents that you wish to cover** for benefits. In general, eligible dependents include your spouse and dependent children until age 26. See the definition of Dependents in the plan's Summary Plan Description booklet for other eligibility requirements.*

Name (First, MI, Last)	Relationship	SSN Required for IRS Tax Reporting (Do not leave blank)	Gender (M / F)	Date of Birth (MM / DD / YYYY)	Employed (Y / N) If of working age	Disabled (Y / N)	Coverage Selection by Individual Medical / Rx Plan (Y/N)
Spouse:	Spouse						
Child:							
Child:							
Child:							
Child:							
Child:							
Child:							

Person	Completed on *(insert date)*
☐ Employee	
☐ Spouse	

Employee Name: _____

Other Coverage - REQUIRED Failure to provide COMPLETE and ACCURATE information, including timely notice of relevant changes during the plan year will be considered insurance fraud and could result in a financial penalty, loss of coverage, and separation of employment.

While enrolled on the Greenfield-Central Community School Corporation medical plan:

a. Will you or any eligible dependents(s) **ALSO** have coverage on **any other plan?** (including Medicare, Tricare or Medicaid?) ☐ Yes ☐ No

b. Are **you** or a **former spouse required by court decree to cover any of the dependents enrolled** in any of the plans? ☐ Yes ☐ No

***If yes**, please attach only the relevant pages of the decree establishing the court order. Court decree information attached?* ☐ Yes ☐ No

Name of ALL Person's Covered by other plans & Coverage Type(s) they have (including yourself):

Dependent Name	**Coverage Type** *Medical / Rx (Y/N)*	**Plan Name or Employer Name**	Carrier/Plan/Employer *Contact Information Phone #*	Effective dates of other coverage

Acknowledgement / Authorization

I hereby apply for or decline Group Benefits(s) for which I am eligible under this Employer. In addition, I authorize my employer to reduce from each pay check, on a pre-tax basis, the contributions shown above for benefits elected. (Note: In accordance with IRS code, some benefits may be after-tax.)

If you do not authorize your employer to reduce from each pay check on a pre-tax basis, the contributions shown above for benefits elected, please check here: ☐

If I participate in the Section 125 Flexible Benefit Plan, I further understand that (a) because of the pre-tax reduction in my salary, there could be a slight reduction in my social security benefits available at retirement and (b) my employer cannot be responsible for any tax liabilities which may subsequently occur as a result of my participation in the Section 125 Flexible Benefit Plan. If I participate in the voluntary products, my employer may continue to reduce on a pre or post tax basis as previously enrolled until an authorized change is made during an open enrollment period or major life event. I understand that I have the right to change my elections if (a) I experience a "major life event" such as marriage, loss of coverage, addition/deletion of dependent; or (b) the amount of premiums that I contribute during the plan year changes. Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Employee's Signature _____ Date _____

For Office Use Only

Effective Date: _____